ILLINOIS DEPARTMENT OF Healthcare and Family Services

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PROVIDER BULLETIN
Update H200-06-01

DATE: September 1, 2006

TO: Participating Hospitals: Chief Executive Officers, Chief Financial Officers, and Patient Accounts Managers

RE: New Source of Admission and Patient Status Codes for UB-92 and Cost Outlier Payment Calculation Revision

The purpose of this bulletin is to provide information on new codes approved by the National Uniform Billing Committee (NUBC) and to advise providers of a change in the cost outlier payment calculation.

NUBC Codes
The NUBC has approved the use of a new Source of Admission code and Patient Status code. Both are effective with admissions occurring on and after January 1, 2006.

- Source of Admission D – Transfer from Hospital Inpatient in the Same Facility Resulting in a Separate Claim to the Payer.

- Patient Status Code 66 – Discharged/transferred to a Critical Access Hospital (CAH).

The DRG Payment Calculation Worksheet in Appendix H-22f, [Pages 1 and 2], of the Handbook for Hospitals has been updated to reflect the new codes.

Cost Outlier Payment Calculation
As a result of an amendment to 89 Illinois Administrative Code 152, the cost outlier payment calculation for admissions occurring on and after July 1, 2006, will change. An explanation of how the change impacts hospitals reimbursed by DRG and per diem reimbursement methodologies is provided below.

For DRG-reimbursed hospital services with admissions on and after July 1, 2006, the Specific Fixed Loss Threshold used in the cost outlier payment calculation will be multiplied by 1.47. The DRG Payment Calculation Worksheet in Appendix H-22f, [Page 4], of the Handbook for Hospitals has been updated to reflect the new multiplier.

For per diem-reimbursed hospital services with admissions on and after July 1, 2006, a factor of 0.18 will be used in the outlier payment calculation. The outlier payment calculation worksheet for per diem-reimbursed hospitals in Appendix H-22f, [Pages 4a and 4b], of the Handbook for Hospitals has been updated to reflect the new factor.

This bulletin and the replacement handbook pages may be obtained from the department's Web site at: <http://www.hfs.illinois.gov/hospitals/>. The revisions in the replacement pages are identified by an "=" to the left of the affected text. Some revisions do reflect policy changes; however, others are simply updates in terminology. Paper copies of the revised pages may be obtained by written request. To ensure delivery, you must specify a physical street address when requesting a paper copy.

You may submit your written request to the address below, or fax or e-mail it as noted:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: (217) 557-8800 / E-Mail Address: hfs.ppu@illinois.gov

Providers wishing to receive e-mail notification, when new provider information has been posted by the department, may register at the following HFS Web site:
http://www.hfs.illinois.gov/provrel

Electronic claim submission via the Internet is available by registering on the department's Medical Electronic Data Interchange, Internet Electronic Claims (MEDI/IEC) System at: <http://www.myhfs.illinois.gov/>. The MEDI/IEC System is available to enrolled providers and their authorized staff, claim submitting agents and payees. During the registration process, you will be given access to specific claim formats based upon your enrollment status with the department.

Instructions for updating the Handbook for Hospitals:

Remove appendix Pages H-22f (1) and (2) dated March 1996 and replace with the updated Pages (1) and (2) dated July 2006.

Remove appendix Page H-22f (4) dated August 2005 and replace with the updated Page (4) dated July 2006.

Remove appendix Pages H-22f (4a) and (4b) dated August 2005 and replace with the updated Pages (4a) and (4b) dated July 2006.

DRG Payment Calculation Worksheet
Basic and Final Price
Admissions 07/01/95 and After

[1] DRG code (from the voucher): _____
If one of the following is true, **do not complete the form.** The claim is not subject to the DRG PPS reimbursement methodology.

=
- The category of service is not 20.
- The DRG code is 103, 436, 462, 480, or 481.

[2] Hospital base price (Table A, item 8) _____

[3] DRG relative weighting factor (from Table B) _____

[4]= Transfer-in adjustment factor _____
- For DRGs 370-375 and admission source 4, subtract 0.2012.
- For DRGs 385-391, 985-987 and 989 and admission source 4, add 0.2012.
- For admissions 01/01/06 and after, for DRGs 370-375 and admission source D, subtract 0.2012.
- For admissions 01/01/06 and after, for DRGs 385-391, 985-987 and 989 and admission source D, add 0.2012.
- In all other situations, use 0.0000.

[5] Adjusted weighting factor (line [3] + line [4]) _____

[6] DRG base price (line [2] x line [5]) _____

[7] Transfer out adjustment factor (from page 2, line [8]) _____
(1.000, unless patient was transferred to another short-term hospital)

[8] Transfer adjusted DRG price (line [6] x line [7]) _____

Outlier adjustment:

[9] Length of stay (from page 3, line [10]) _____

[10] Cost (from page 4, line [16]) _____

[11] Larger of the two outlier amounts (line [9] or line [10]) _____

[12] DRG price (line [8] + line [11]) _____

Add-ons (from Table A):

[13] Capital cost (from Table A, item 9) _____

[14]*=Disproportionate Share Rate x Covered Days= _____

[15]*=Medicaid Percentage Adjustment Rate x Covered Days= _____

[16]*=Medicaid High Volume Rate x Covered Days = _____
- For admissions 10/01/93 and after, use the per diem rate that is in effect on the date of admission

[17]= Total reimbursement (sum of line [12] through line [16]) _____
(This total does not include adjustments for co-payment, third-party liability , and other adjustments)

*These rates are identified in annual rate letters from the department.

Transfer-out Adjustment
Admissions 07/01/95 and After

[1]= Patient status code (from claim): _____

= If patient status at discharge is NOT coded 02, transfer to another short-term hospital, or (after 01/01/06) 66 - discharged/transferred to a Critical Access Hospital (CAH), then STOP. The claim is not to be adjusted for a transfer-out proration. Go to line [8] and enter one (1.0000).

[2]= Claim DRG _____

Computed adjustment factor:

[3]= Length-of-stay (covered days) _____

[4] Geometric mean length-of-stay (GLOS) (from Table B) _____

[5] Computed adjustment factor (line [3] divided by line [4]) _____

[6] Lesser of line [5] and 1.000 _____

[7] Transfer-out adjustment for exceptions _____
- For DRGs 385, 456, and 985, enter 1.0000
- In all other situations, enter 0.0000

[8] Transfer-out adjustment factor
(Greater of line [6] or line [7]) _____

Carry the final figure from line [8] over to Page 1 line [7].

Length-of-stay Outlier
Admissions 07/01/95 and After

[1] DRG code (from claim): _____
If the DRG code is within the range of 424-432, then **STOP**. The claim is not subject to reimbursement for length-of-stay outliers.

[2]= Length-of-stay (covered days) _____

[3] DRG outlier cut-off threshold (OCT) (from Table B) _____

[4] Outlier days (line [2] - line [3]) _____
If the result in [4] is less than or equal to zero, then **STOP**.
The claim is not subject to reimbursement for length-of-stay outliers. Go to line [10] and enter zero (0).

[5] DRG federal portion (from Table A, item 6) times
DRG weight (from Page 1, line 5) _____

[6] Geometric mean length-of-stay (GLOS) (from Table B) _____

[7] DRG base price per diem (line [5] divided by [6]) _____

[8] Marginal cost factor: 0.47

[9] Multiply (line [7] x line [8]) _____

[10] Day outlier payment (line [4] x line [9]) _____

Carry the final figure from line [10] over to Page 1 line [9] of the DRG Payment Calculation Worksheet.

Cost Outlier for DRG-Reimbursed Hospitals
Admissions 12/03/01 Through 06/30/05 And Admissions 07/01/05 and After

[1] DRG code (from paid claim): _____

[2]= Total charges _____

[3]= Noncovered charges _____

[4] Net charges (line [2] - line [3]) _____

[5] IME factor (from Table A, item 18) _____

[6] IME adjusted charges (line [4] divided by line [5]) _____

[7] Cost to charge ratio (from Table A, item 3) _____

[8] Net covered cost (line [6] x line [7]) _____

[9] Federal rate (from Table A, item 6) _____

[10] DRG relative weighting factor (from Page 1, line 5) _____

[11] National DRG rate (line [9] x line [10]) _____

[12] Specific fixed loss threshold (Table A, item 17) **x1.22**
admissions 12/03/01 through 06/30/05
OR _____
= Specific fixed loss threshold (Table A, item 17) **x 1.40**
for admissions 07/01/05 through 06/30/06
OR
= Specific fixed loss threshold (Table A, item 17) **x 1.47**
for admissions 07/01/06 and after

[13] Cost outlier threshold (line [11] plus line [12]) _____

[14] Gross outlier cost (line [8] - line [13]) _____
If the result in [14] is less than or equal to zero, then **STOP**.
The claim is not subject to reimbursement for cost outliers.
Go to line 16 and enter zero (0).

[15] Marginal cost factor (effective 1/1/95) 0.80

[16] Cost outlier adjustment (line [14] x line [15]) _____

Carry the final figure from line [16] over to Page 1 line [10] of the DRG Payment Calculation Worksheet.

Outlier Adjustment Calculation for
Per Diem Priced Claims

For a disproportionate share provider to qualify for an outlier, the patient must be under age six. For a non-disproportionate share provider, the patient must be under age one.

Provider information needed:
*****daily per diem rate
*****daily disproportionate share rate
*****daily MHVA rate
*daily MPA rate
outlier standard deviation amount (in effect on admission date)
outlier cost-to-charge ratio (in effect on admission date)

Claim information needed:
total covered charges
total covered days

*****If the date of service crosses a rate period where there is a rate change, you will have to do steps 5 through 11 twice (one calculation for each rate period) and then add them together.

[1] Outlier standard deviation $_____

[2] Total covered charges $_____

Compare total covered charges to the outlier standard deviation. If total covered charges are less than the outlier standard deviation, then **stop**. The claim is not eligible for outlier consideration. If total covered charges are greater than the standard deviation, proceed to step 3.

[3] Outlier cost-to-charge ratio _____

[4] Multiply line 2 times line 3 $_____

[5] Per diem rate $_____

[6] Disproportionate share rate $_____

[7] MHVA rate $_____

[8] MPA rate $_____

[9] Total of lines 5, 6, 7, and 8 $_____

[10] Number of covered days _____

[11] Multiply line 9 times line 10 $_____

[12] Line 4 total minus line 11 total $_____

[13] If step 12 total is zero or less, **stop**. The claim is not eligible for an outlier.
For admissions between December 3, 2001 and June 30, 2005:
If step 12 is greater than zero, then take step 12 total
X .22 (factor .22 is used for all hospitals) Outlier Amount Due $_____

= **For admissions between July 1, 2005 and June 30, 2006:**
If step 12 is greater than zero, then take step 12 total
X .20 (factor .20 is used for all hospitals) Outlier Amount Due $_____

= **For admissions on or after July 1, 2006:**
If step 12 is greater than zero, then take step 12 total
X .18 (factor .18 is used for all hospitals) Outlier Amount Due $_____

EXAMPLE

Provider information:		**Claim information:**	
***daily per diem rate**	$ 1,219.11	total covered charges	$152,564.09
***daily disproportionate share rate**	$ 60.60	total covered days	45
***daily MHVA rate**	$ 87.38		
*daily MPA rate	$ 52.40		
outlier standard deviation amount	$52,682.40		
outlier cost-to-charge ratio	.50		

[1]	Outlier standard deviation		$ 52,682.40
[2]	Total covered charges		$ 152,564.09

Compare total covered charges to the standard deviation. If total covered charges are less than the outlier standard deviation, then **stop**. The claim is not eligible for outlier consideration. If total covered charges are greater than the standard deviation, proceed to step 3.

[3]	Outlier cost-to-charge ratio		.50
[4]	Multiply line 2 times line 3		$ 76,282.05
[5]	Per diem rate	$ 1,219.11	
[6]	Disproportionate share rate	$ 60.60	
[7]	MHVA rate	$ 87.38	
[8]	MPA rate	$ 52.40	
[9]	Total of lines 5, 6, 7, and 8	$ 1,419.49	
[10]	Number of covered days	45	
[11]	Multiply line 9 times line 10		$ 63,877.05
[12]	Line 4 total minus line 11 total		$ 12,405.00

[13] If step 12 total is zero or less, **stop**. The claim is not eligible for an outlier.

For admissions between December 3, 2001 and June 30, 2005:
If step 12 is greater than zero, then take step 12 total
X .22 (factor .22 is used for all hospitals): Outlier Amount Due $ 2,729.10

= **For admissions between July 1, 2005 and June 30, 2006:**
If step 12 is greater than zero, then take step 12 total
X .20 (factor .20 is used for all hospitals) Outlier Amount Due $ 2,481.00

= **For admissions on or after July 1, 2006:**
If step 12 is greater than zero, then take step 12 total
X .18 (factor .18 is used for all hospitals) Outlier Amount Due $ 2,232.90